Application for Medicare Savings Programs

Alabama Medicaid Agency

NOTE: This is NOT an application for full Medicaid. These programs cover Medicare premiums and deductibles. Medicaid's drug coverage is limited to the drugs covered under Medicare Part D only. Medicaid will not pay for any excluded drugs under Medicare Part D.

Instructions: Read this application carefully and follow all instructions given throughout the form. Answer each question completely and accurately.

1. **Send a copy of your Medicare card to verify your Part A coverage.**
2. **Send a copy of your Social Security card.**
3. **Send verification of the gross (before taxes) amount of your monthly income other than Social Security.**
4. **Sign the application.**
5. **Mail the application to the District Office serving your county. (See last page of this application for a list of District Offices, addresses and phone numbers.)**
6. **Please print using dark ink.**

District Office Use Only

Date Received _____

Date Accepted _____

Circle one:
Medicare Card Rec'd. Yes No
Income Verif. Rec'd. Yes No

Applicant: Name:_____
First Middle/Maiden Last

Mailing Address:_____
P.O. Box City State Zip Code

Street Address:_____
Street City State Zip Code

County where you live _____ Telephone Number (_____) _____
Area Code

Social Security Number: _____ Date of Birth _____

Race: ___ White ___ Black ___ American Indian ___ Hispanic
___ Asian ___ Cuban/Haitian ___ Other

Sex: ___ Female ___ Male

Do you have Medicare Part A (Hospital) Coverage? ☐ Yes ☐ No

Name on Medicare card: _____ **Medicare No.** _____

Sponsor: (If the applicant is unable to complete the application or provide additional information, the Medicaid sponsor should be the person **most** familiar with the financial situation of the applicant.) Please complete the Appointment of Representative form (Page 5 of this application).

Name: _____ Relationship: _____

Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Office Phone: (_____) _____
Area Code Area Code

Are you a U.S. citizen? ☐ Yes ☐ No **Are you a lawfully admitted alien?** ☐ Yes ☐ No

Where were you born? _____
City County State

Do you live in Alabama and plan to stay? ☐ Yes ☐ No

Marital Status (Marriage Information):

___ Married _____ Date married If married, does your spouse have Medicare? ☐ Yes ☐ No
___ Separated _____ Date separated
___ Divorced _____ Date divorced
___ Widowed _____ Date widowed
___ Single (never married)

Spouse Information: (Complete even if divorced, separated or widowed.)

Name: _____
First Middle/Maiden Last

Date of Birth: _____ Social Security Number _____

Veteran's Status:
Are you a Veteran? ☐ Yes ☐ No Are you a dependent of a veteran? ☐ Yes ☐ No
If yes to either of the above, complete the following:

Relationship to Veteran _____

Veteran's Name:_____ _____
First Middle Last Claim Number

Have you applied for Veteran's benefits under the new Veterans & Survivor's Improvement Act? ☐ Yes ☐ No
If you have not applied for the Veterans & Survivor's Improvement Act benefits, please do so and send verification.

Have you ever applied for or received SSI? ☐ Yes ☐ No

If yes, were you terminated from SSI? When?_____
Month/Year

Do you have medical insurance other than Medicare? ☐ Yes ☐ No If yes, provide information below:

1. Name/Address of health insurance company

_____
_____
_____

Policy/Group Number _____

2. Name/Address of health insurance company

_____
_____
_____

Policy/Group Number _____

(List other policies on separate sheet.)

List names of anyone living in your home: (Name, Age and Relationship to Applicant)

_____
_____

Gross Income: (This means "money coming in" before anything is taken out). Answer the following. Do you or your spouse have "money coming in" from any of the sources listed below? ☐ Yes ☐ No
If yes, fill in the claim number and gross amount. **(A copy of most recent check stub or other verification must be provided.)**

NOTE: If you are applying on behalf of a married individual, the spouse **must** also answer these questions.

Type of Income	Claim Number	Applicant Gross Amount	Spouse Gross Amount	Minor Child Gross Amount	How Often Received? (Quarterly, Annually, etc.)
1. Social Security (include Medicare Premiums)					
2. SSI (Gold Check)					
3. Public Assistance (Welfare)					
4. Railroad Retirement					
5. Veterans Benefits, Pensions, Compensation or Insurance					
6. Federal Civil Service Annuity					
7. State Retirement/Pension					
8. Private Pension					
9. Miner's Benefits					
10. Black Lung Benefits					
11. Cash Contributions (from relatives, friends, others)					
12. Rental (land, buildings, or from roomer)					
13. Personal loans (relatives, friends, others)					
14. Unemployment Compensation					
15. Insurance Annuity or Proceeds					
16. Government Payments on land					
17. Coal, Oil, Gravel Rights and Timber Leases					
18. Royalties					
19. Court Ordered Support					
20. N/A					
21. Other: Specify _____					
22. Other: Specify _____					
23. Legal Settlements					
24. Sheltered Workshop Earnings					
25. Wages/Salary					
26. Self Employment					

RELEASE OF INFORMATION

* I hereby authorize and give my consent for the Alabama Medicaid Agency to obtain information from any source for the purpose of determining my eligibility for Medicaid benefits. I authorize this release form to be in effect for as long as I am on Medicaid regardless of the date that it is signed. I further authorize copies of this document to be used in place of the original. I give my consent for the release of information for those purposes directly related to the administration of the Medicaid program. These purposes include, but are not limited to, establishing eligibility for benefits, determination of the amount of medical assistance received, the provision of services, and iinvestigation of program violations.

AFFIRMATION AND AGREEMENT

* I give permission to the Alabama Medicaid Agency to use my social security number to get information about my resources and income from banks, financial institutions, employers, and other county, state and federal agencies, and/or to see if I qualify for assistance or to see if I have insurance.
* If I am approved for Medicaid, I assign all insurance and medical support benefits to Medicaid. If Medicaid pays my bills, then my insurance or other benefits (such as lawsuit settlements) must be used to pay Medicaid back. I agree to help and cooperate with Medicaid in identifying and collecting this money, or I may lose my Medicaid benefits. I give permission for my insurance company, employer, and others to give needed information to Medicaid in order to administer the Medicaid program.
* I understand that if this application or other information shows that I may be eligible for payments or benefits from other sources, I am required to apply for them.
* I understand that my case is subject to review by State and Federal Quality Control and that I must cooperate in completing the application process or in any subsequent reviews of my eligibility, including reviews resulting from reported changes, recertification, or as a part of a State or Federal Quality Control Review.
* I understand that resources that have been sold, transferred, disposed of, or given away within the past 36 months (60 months for transfers to trusts) will not affect my application for Medicaid for the Medicare Savings Programs, but may affect eligibility for Medicaid in a medical institution.

RESPONSIBILITIES

* I agree to notify the Medicaid District Office within ten (10) days, if there is a change in my address, living arrangements, family size, income or resources.

FALSE STATEMENTS

I know that anyone who makes or causes to be made a false statement, representation or omission of a material fact in an application or for use in determining eligibility for Medicaid commits a crime punishable under Federal or State law or both. I affirm under penalty of perjury that all information I give in this document or in support of it is true.

_____ Date: _____

Signature of Applicant or Representative

_____ Date: _____

Signature of Applicant's Spouse or Representative

_____ Date: _____

Witness' Signature (If applicable)

Medicaid Eligibility Policies and Procedures are in compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Federal Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.

APPOINTMENT OF REPRESENTATIVE

I hereby appoint: _____ (Sponsor's Name) as my legal representative to act in my stead and on my behalf to apply, reapply and make claim for Medicaid benefits under Title XIX of the Social Security Act from the Alabama Medicaid Agency, hereby ratifying and confirming the acts of my said representative on my behalf. This appointment authorizes my said representative to fully act in my stead in connection with all Medicaid matters involving me, including, but not limited to, making applications, reapplications and claims of all kinds, accepting and giving notice in connection with eligibility determinations and Fair Hearings, requesting information, and presenting and eliciting evidence. This appointment shall remain in full force and effect until I have notified the Alabama Medicaid Agency in writing that this authority has been withdrawn.

Done this the _____ day of _____, 20 _____.

WITNESSES:

_____ _____

(Signature of Medicaid Claimant)

_____ _____

(Social Security Number)

If claimant cannot sign his/her name but can make a mark; this is acceptable if witnessed by two adults.

The mark may be labeled. Example: X (Her mark) Jane Doe.

If claimant cannot sign his/her name or make a mark and there is no one legally designated as guardian, conservator, etc., representative must answer the questions below:

What is your relationship to claimant? _____

Why can't claimant sign? _____

To what extent are you responsible for claimant? _____

If claimant has a legally appointed guardian, conservator or someone with durable power of attorney who will represent him/her for Medicaid purposes, claimant's signature on this form is not required. Representative should sign the Representative portion of the form only and attach to this form a copy of evidence of legal authority to act on claimant's behalf (Letter of Conservatorship/Guardianship or Durable Power of Attorney).

ACCEPTANCE OF APPOINTMENT

I hereby accept the foregoing appointment. I certify that I have not been suspended or prohibited from practice before the Alabama Medicaid Agency and am not otherwise disqualified from acting as an appointed representative. I acknowledge that representations and applications made by me on behalf of the claimant are made under an affirmation which subjects me to penalties for perjury and that false statements may subject me to penalties or fraud.

My relationship to the above is _____ (Attorney, relative, etc.)

Done this the _____ day of _____, 20 _____.

WITNESSES:

_____ _____

(Signature of Sponsor/Representative)

_____ _____

(Address)

_____

(City, State)

_____

(Telephone Number)

Medicaid District Offices

Address	Telephone Number	Counties served		
Auburn-Opelika District Office 1716 Catherine Court, Suite 1A Auburn, AL 36830-9938	1-800-362-1504 334-887-3840 (FAX)	Bullock Chambers Clay Coosa	Lee Macon Randolph	Russell Talladega Tallapoosa
Birmingham District Office 468 Palisades Blvd. Birmingham, AL 35209-5154	1-800-362-1504 205-414-9335 (FAX)	Jefferson	St. Clair	
Decatur District Office 2119 Westmeade Dr. SW., Suite 1 Decatur, AL 35603-1050	1-800-362-1504 256-353-1799 (FAX)	Cullman Jackson	Madison Morgan	
Dothan District Office 2652 Fortner Street, Suite 4 Dothan, AL 36305-3203	1-800-362-1504 334-794-3741 (FAX)	Barbour Coffee Conecuh	Covington Dale Geneva	Henry Houston
Florence District Office 214 E. College Street Florence, AL 35630-5606	1-800-362-1504 256-740-0228 (FAX)	Colbert Franklin Lauderdale	Lawrence Limestone	Marion Winston
Gadsden District Office 200 West Meighan Blvd., Suite D Gadsden, AL 35901-3200	1-800-362-1504 256-546-4973 (FAX)	Blount Calhoun Cherokee	Cleburne Dekalb Etowah	Marshall
Mobile District Office 3280 Dauphin Street Suite B 100 B Mobile, AL 36606-4049	1-800-362-1504 251-471-6930 (FAX)	Baldwin Escambia	Mobile Washington	
Montgomery District Office 501 Dexter Avenue (P.O. Box 5624, Zip 36103-5624) Montgomery, AL 36104-3744	1-800-362-1504 334-242-3835 (FAX)	Autauga Crenshaw Elmore	Montgomery Pike	
Selma District Office 106 Executive Park Lane Selma, AL 36701-7734	1-800-362-1504 334-418-0036 (FAX)	Butler Chilton Choctaw Clarke	Dallas Lowndes Marengo	Monroe Perry Wilcox
Tuscaloosa District Office 907 22nd Avenue Tuscaloosa, AL 35401-5822	1-800-362-1504 205-345-9414 (FAX)	Bibb Fayette Greene Hale	Lamar Pickens Shelby	Sumter Tuscaloosa Walker